Clinical Commissioning Group (CCG) spend on Voluntary, Community and Social Enterprises (VCSEs), 2018/19

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GitHub: <https://github.com/AlexGibsonPlymouth/3SC.git>

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Clinical Commissioning Group (CCG) spend on Voluntary, Community and Social Enterprises (VCSEs) , 2018/19

# Introduction

As part of a drive to improve public expenditure transparency HM Treasury issued guidance in 2013 requiring all government bodies to publish, with few exceptions, “all individual invoices, grant payments, expense payments or other such transactions that are over £25,000”[[1]](#footnote-1).

To be published in CSV format on the *www.data.gov.uk* website as well as locally (e.g. on individual CCG websites), the following was to be reported for each item of expenditure:

* Department Family (e.g. Department of Health) and Entity (e.g. NHS Barnet CCG)
* Expense Type (the general nature of the expenditure, e.g. ‘Mental Health – Adults’)
* Expense Area (the part of the entity that has spent the money, e.g. ‘Out of Hours’)
* Supplier Name and Supplier Postcode
* Narrative Description of the transaction,
* Date and the ‘Amount in Sterling’

In theory, therefore, a rich and comprehensive dataset should now cover all “over-threshold” expenditure made by all public bodies from 2014-15 onwards. An enormous amount of data has indeed been made publicly available, and this has triggered some innovative analyses of NHS spending[[2]](#footnote-2). Nevertheless, for reasons that will become apparent, the wealth of data has not received the level of attention that might have been expected.

In the context of the present study (*Commissioning, Co-commissioning and Being Commissioned; the NHS and Third Sector Organisations*) the aim was to use this data to quantify how different CCGs commission VCSEs as opposed to other kinds of providers (NHS-owned, corporate, etc.). As detailed in the research protocol[[3]](#footnote-3), the resulting insights were to:

1. guide the initial ‘maximum-variety sample of study sites’,
2. detail the nature of VCSE engagement in the selected study sites, and
3. offer a broader cross-sectional and longitudinal perspective on patterns of VCSE commissioning across the country as a whole.

As described below, the first two objectives were met and, with some limitations, the “over-threshold” expenditure data proved invaluable. It was also possible to construct a nearly complete cross-sectional analysis of commissioning patterns in 2018-19. Intractable obstacles caused by the ongoing reorganisation of CCGs, and their eventual replacement by Integrated Care Systems (ICSs), meant it was not possible to undertake a longitudinal analysis of the data other than for the six study-sites. This analysis is not reported here to ensure anonymity of the case study sites, a consideration which restricts the level of detail that can be provided in later sections of this report.

CCG reorganisation/replacement also meant that it was impossible to provide a full “reproducible analytical pipeline” (RAP)[[4]](#footnote-4) capturing data acquisition, cleaning and analysis. RAP requires persistent open-source data and **all** CCG websites from which data were retrieved have now disappeared. Moreover, (1) many CCG datasets were in practice only available via Freedom of Information (FoI) requests, and (2) establishing the VCSE status of suppliers involved significant manual searching of the internet.

In place of a full RAP, all ‘raw’ 2018/19 CCG “over-threshold” expenditure datasets used in the project have been made available via the project’s *github* website[[5]](#footnote-5) along with a detailed description of the data cleaning and supplier categorisation workflow (below). The resulting analytical dataset is included on the project’s *github* website, along with all non-disclosive R scripts and outputs used to analyse patterns of CCG commissioning (as reported below).

# Data Collection & Cleaning

The most recent accounts available when the data were required (in late 2019) were for 2018-19. These referred to the 195 CCGs then extant, although the number had already dropped to 191. We were, in other words, already dependent on historic data and, as detailed in Table 1, the reorganisation of commissioning bodies gathered pace during the study period.

Table : Number of Commissioning Bodies (CCGs and ICSs) by Year

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| *Date* | *Count* |  | *Date* | *Count* |  | *Date* | *Count* |
| April 2014 | 211 CCGs |  | April 2017 | 207 CCGs |  | April 2020 | 135 CCGs |
| April 2015 | 210 CCGs |  | April 2018 | 195 CCGs |  | April 2021 | 106 CCGs |
| April 2016 | 209 CCGs |  | April 2019 | 191 CCGs |  | July 2022 | 42 ICSs |

This reorganisation has posed significant problems. Many newly created CCGs/ICSs incorporate expenditure data relating to their precursors into their websites, but this was, and remains, far from universal. Extensive use of FoI requests may have retrieved this data, but experience with the FoI process, and of the time it takes to identify VCSE suppliers, meant undertaking a longitudinal analysis was not a reasonable proposition and this objective was not pursued.

The focus was thus on the “over-threshold” accounts for the 195 CCGs operating in 2018-19. The *www.data.gov.uk* website and all CCG websites were searched and, if found, the relevant accounts were downloaded. Disappointingly, given the intention of the 2013 guidance, FoI requests then had to be sent to 106 of the 195 CCGs. Of these, 12 because no accounts were publicly available, 11 because one or more of the monthly accounts were missing, corrupted or referred to the wrong CCG, and 83 because the data, contrary to the guidance, were provided in PDF format and could not be reliably converted into machine-readable numeric data[[6]](#footnote-6).

In most cases the FoI process was quick and straightforward, but 17 requests were rejected and a formal follow-up was needed. By March 2020 there remained four CCGs which had yet to provide useable data. With the arrival and obvious impact of the COVID-19 pandemic we stopped pursuing our FoI requests, leaving us with data for 191 of the 195 CCGs.

## Preliminary Evaluation of CCG Accounts

To test their likely veracity, all CCG expenditure accounts were compared against the most recent available NHSE CCG consolidated accounts (for 2016-17)[[7]](#footnote-7). Given the time lag some variation was expected, but two CCGs accounts were badly out-of-line. Airedale, Wharfedale & Craven CCG captured 47.5% of the NHSE-reported spend, and Eastern Cheshire CCG just 20.8%. It was clear that these accounts could not be relied upon.

We were thus left, as summarised in Table 2 below, with accounts for 189 of the 195 CCGs extant in 2018-19. From these were extracted: (1) CCG Name, (2) Expense Area, (3) Expense Type, (4) Supplier and (5) Amount. Only 1287 records (0.19%) had a blank, ‘unknown’, ‘redacted’ or uninformative (e.g. ‘Payroll Payovers’ or ‘Programme Projects’) supplier name, although 4.0% and 4.7% of entries for ‘Expense Area’ and ‘Expense Type’ respectively were missing, the vast majority in just 14 CCGs. In fact, although these fields initially appeared useful as they occasionally state whether a supplier was ‘Independent’, ‘Commercial’, ‘Not-for-profit’, ‘Voluntary’, or ‘Public Sector’, cross-referencing against the status of named suppliers shows that these statements cannot used to determine whether suppliers are VCSE. Our categorisation of suppliers thus rests entirely on linking supplier names given in the accounts with organisations listed in the Charity Commission and Company House Registers, along with information found on organisations’ websites.

Table : Availability of CCG “over-threshold” accounts and resulting Analytical Dataset

|  |  |  |
| --- | --- | --- |
| No data available online or via FoI request | | * East Leicestershire and Rutland CCG |
| No machine-readable data available (badly formatted PDF files online with no alternative made available following FoI request) | | * City & Hackney CCG * Newham CCG * Horsham Mid Sussex CCG |
| Demonstrably unreliable data (serious mismatch with NHSE’s 2016-17 CCG consolidated accounts) | | * Airedale, Wharfedale and Craven CCG * Eastern Cheshire CCG |
| Working Dataset | * 189 CCGs (of total 195 CCGs in 2018-19) * 689,536 records (transactions) * 622,514 payments (positive amounts = expenditure) * £72.179 billion of expenditure * 67,022 income receipts (negative amounts = income) * £2.668 billion of income * 226,138 invoices for expenditure over £25k (36.3% of total) * £70.525 expenditure via invoices over £25k (97.7% of total) | |

## Focusing on invoices >£25k

An important difference between CCG accounts was the extent to which they observed the recommended >£25k threshold. As illustrated in Figure 1 below, this varied hugely; from the 21 CCGs which only contained invoices over £25k through to Merton, Gloucestershire and Wandsworth CCGs where more than 90% of invoices were for sums less than £25k. This undoubtedly reflects variations in recording practice rather than actual expenditure.

To ensure like-for-like CCG comparisons, all invoices of less than £25k have been stripped from the working dataset. This reduced the number of uniquely *named* suppliers from 13,455 to 10,930 although, reflecting a frustrating level of imprecision in the use of supplier names, this represents around 10,562 unique suppliers. This can only be a ‘best estimate’ as algorithmic fuzzy matching and manual interrogation of supplier names cannot capture all instances where different names were used to describe the same company. For instance, the company called “ACCI” in one place is (almost certainly) what is elsewhere known as the “African Caribbean Community Initiative”. Innumerable such instances have been found, but, inevitably, many will have been missed.

A picture containing text, screenshot

Description automatically generated

Figure : Percent invoices >£25k by CCG

## Generic ‘Suppliers’ and Ad Hoc Exclusions

There is a small but significant number of suppliers named ‘GP’, ‘Primary Care’ and ’Prescribing Support Services’. Company House includes ‘GP Ltd’, ‘Primary Care Limited’ and ’Prescribing Support Services Limited’, but it seems highly likely that these names were being used generically. These supplier ‘names’ have been retained in the analytical dataset (and the first two categorised as ‘GP Services’), but they will clearly refer to an unknown number of individual suppliers. There are also a number of Personal Health Budget (PHB) and Continuing Healthcare (CHC) payments made to individuals – identified by name, anonymised coded name (e.g. ‘02EKS2540’) or, most commonly, as ‘REDACTED’. All payments to individuals have been excluded from the analytical dataset..

Recognising such limitations, the ***analytical dataset*** (available on *github)* includes 225,889 invoices of £25k or more across 189 CCGs and refers to 10,478 unique suppliers. These transactions account for £70.496 billion, which is 97.7% of total CCG expenditure.

## Recognising the potential impact of using data for 2018/19

The largest suppliers to CCGs were the NHS trusts and Local Authorities (LAs) which undertook the vast bulk of clinical, mental health and community service activity. Thus, nationally, LAs and NHS trusts account for 83.3% of all 2018-19 expenditure by way of invoices over £25k although, as indicated in Figure 2 below, this varied significantly between CCGs; from only 52.7% and 57.3% in East Staffordshire and North East Lincolnshire respectively, to over 90% in seven CCGs (Wirral, South Sefton, Thurrock, Manchester, South Devon & Torbay, Morecambe Bay and Crawley).

This reflects the extent to which different CCGs were, at that time, commissioning independent service providers, whether corporate or VCSE (see Section 7 below). In North East Lincolnshire, for instance, two Community Interest Companies (Navigo and Focus Independent Social Work CIC) and a Community Benefit Society (Care Plus Group (North East Lincolnshire) Ltd) accounted for 24.7% of all CCG expenditure. In East Staffordshire, meanwhile, 30.9% of CCG spend was received by Virgin Care Services. Its involvement was, however, short-lived as, following a contractual dispute, on 1st April 2020 the Midlands Partnership NHS Foundation Trust took over services previously provided by Virgin Care. At the time part of the Virgin Group, in December 2021 Virgin Care was rebranded as the HCRG Care Group and acquired by Twenty20 Capital[[8]](#footnote-8), a venture capital investment company which claims that it looks “for significant returns in 2-5 years”[[9]](#footnote-9). The change in supplier and resulting shift in supplier status (from corporate to NHS), along with the background churn in ownership structures (albeit subsequent to Virgin pulling out of the East Staffordshire contract), illustrates a key problem with the analysis. It is based on 2018-19 data and not only has the commissioning landscape since transformed (from 195 CCGs to 42 ICSs by July 2022) but, in some localities, so too has the provider landscape.

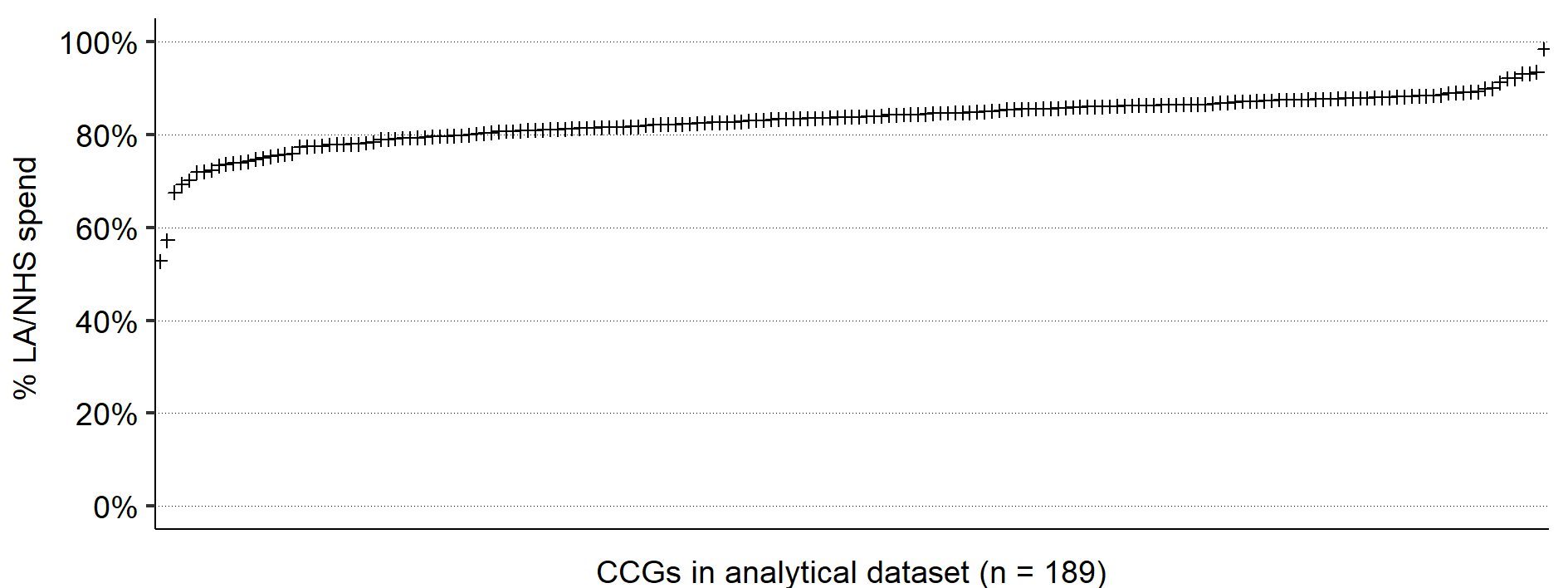


Figure : Proportion >£25k spend to LAs and NHS Trusts

## Recognising potential variation in the comprehensiveness of the CCG accounts

The occasionally very high proportion of CCG expenditure accounted for by LAs and NHS Trusts points towards a further possible limitation with the data. Nationally, 8.9% of CCG expenditure is directed towards organisations identified as suppliers of primary care services, largely GPs. Yet, as illustrated in Figure 3 below, this varies from less than 0.1% (for Greater Huddersfield and Crawley) to over 20% (for West Norfolk, the East Riding of Yorkshire and Hull). This partly reflects difficulties identifying GPs in the accounts (although 6,288 primary care organisations have been identified) and the fact that some primary care activity will be missed because it was being undertaken by organisations with a much wider remit. But the variation also seems to reflect differences in the comprehensiveness of the CCG accounts.

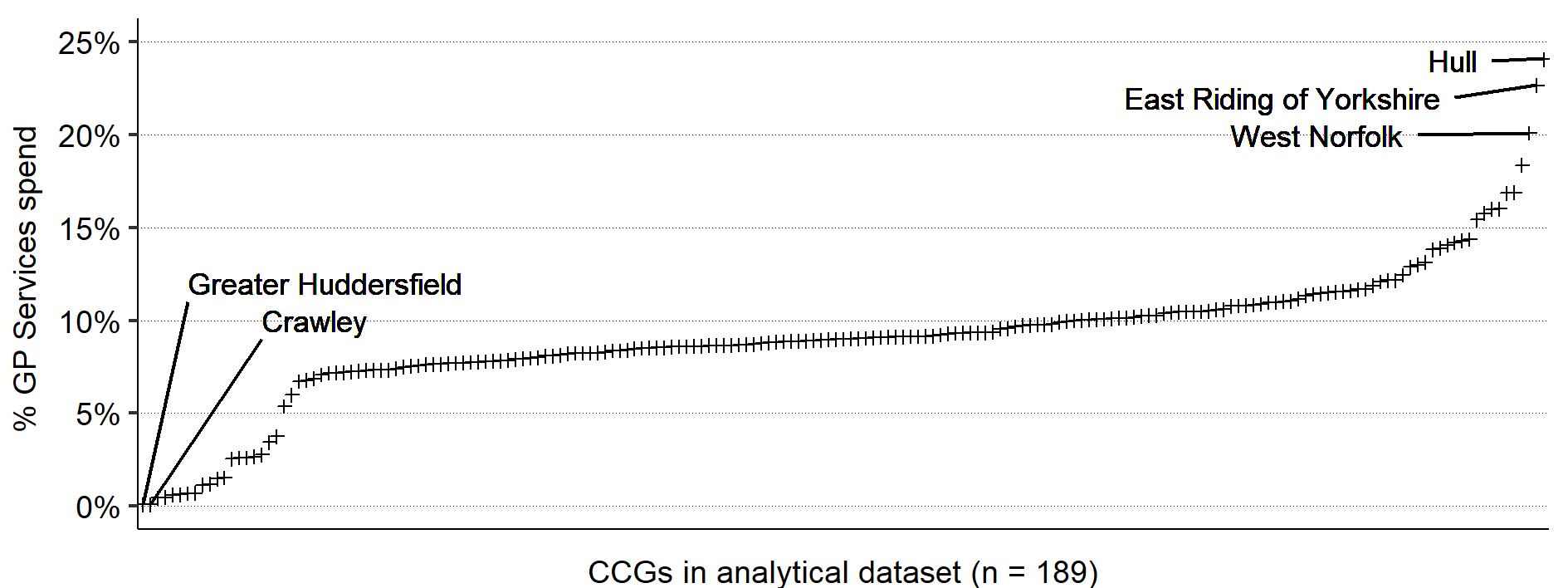


Figure : Proportion >£25k spend on GP Services

A list of all GPs receiving payments from the NHS in 2018-19[[10]](#footnote-10) reveals that the proportion of GPs included in the “over-threshold” accounts varies hugely. In Greater Huddersfield, payments to only 2 of 38 known GPs are recorded. They received just 2.47% of the total NHS payment to Huddersfield GPs. Similarly, the Crawly CCG accounts include only 1 of 12 known GPs (receiving 9.2% of total payments).

In contrast, in West Norfolk 17 of 21 known GPs (receiving 70.5% of total GP payments) are to be found in the “over-threshold” accounts; in the East Riding of Yorkshire the figure is 23 of 33 GPs (79.9% of payments); and in Hull it is 33 of 41 GPs (85.6% of total GP payments).

Such disparities may stem from local differences in how, since 2015, NHS England has been delegating full or partial responsibility for commissioning primary care services to CCGs. If so, accounting for expenditure on primary care may be uniquely problematic, but it must be accepted that, in a large-scale national overview of spending patterns, unknown CCG-level differences may exist regarding what is considered within the remit of the “over-threshold” accounts.

# Identifying Suppliers: The Workflow

As noted above, determining the VCSE status of individual suppliers depends entirely on linking names in the accounts to various public registers and/or their public-facing websites. The workflow was iterative, but was broadly as follows:

1. From all valid invoices >£25k (n= 225,889 / £70.496bn.), use fuzzy matching algorithms (R Statistics *fuzzyjoin* package[[11]](#footnote-11)) and manual name comparisons to determine, so far as possible, the actual unique suppliers (n=10,562) behind the *named* suppliers (n=10,929)
2. Manually identify all NHS Trusts, Health Boards, CCGs and Commissioning Support Units (plus misc. NHS organisations such as NHS Property Services, NHS Pensions Agency, etc.): 538 unique suppliers (5.1% of all suppliers), 71,424 invoices (31.6% of all invoices) and £54.263bn. (77.0% of all expenditure). This excludes non-NHS organisations ‘branded’ as NHS organisations (e.g. various ‘NHS Treatment Centres’).
3. Manually identify all local councils (county, metropolitan, borough, etc): 212 unique suppliers (2.0%), 11,540 invoices (5.1%) and £4.458bn. (6.3%).
4. Search the CQC active and inactive provider registers[[12]](#footnote-12) for supplier names, using fuzzy matching algorithms followed by manual checking of apparent matches (to address the large number of false positives). The CQC registers provide information on each supplier’s ‘Sector’ (e.g. ‘Primary Medical Services’ or ‘Social Care Organisation’), whether a care home and, where appropriate, its Charity Commission (CC) and Company House (CH) registration number.
5. Use fuzzy matching and manual checking (as above) to search the list of practices in *NHS Payments to General Practice, England, 2018/19* to determine whether non-NHS/LA suppliers are GPs, adding to those identified at Step 4 and those with keywords ‘Dr’, ‘Drs’, ‘Medical Centre’, ‘Medical Practice’, ‘Surgery’ and similar. Putative practices are confirmed by searching for a corresponding website. Ownership status (including CH registration number) is noted if clearly stated on the website, though this is rare.
6. Use fuzzy matching and manual checking (as above) to search CC and CH Registers for (a) all non-NHS/LA supplier names found in the “over-threshold” accounts and (b) CC/CH registration numbers found at Steps 4 and 5.
7. For those suppliers not yet identified as NHS or LA organisations, or already found in the CC/CH registers, manually search the internet for supplier websites. The flexible use of supplier names in the accounts makes this somewhat hit-or-miss but, if found, the supplier’s website is searched for CC/CH registration numbers (a legal obligation, albeit clearly not always observed) – in which case details are extracted from CC/CH registers as above – and for explicit statements that they are ‘not-for-profit’, ‘social enterprise’ or ‘volunteer-led’ organisations. Evidence from websites is also used to place suppliers into a number of general ‘supplier sector’ categories (Table 3).
8. Finally, as the focus is on finding all VCSE organisations, further, more intensive, internet searches were undertaken for suppliers tagged in the ‘Expense Type’ and ‘Expense Sector’ entries as being ‘Not-for-Profit’ or ‘Voluntary’.

The process is far from perfect, and misidentification and non-identification remain significant issues. As others have noted[[13]](#footnote-13), although the legislation driving transparency is ambitious, there is no requirement or guarantee that the data are accurate!

Nevertheless, as detailed in Tables 3 and 4 below, the vast bulk of CCG expenditure in the “over-threshold” accounts has been accounted for. Idiosyncratic use of names and acronyms means 188 (1.8%) suppliers, receiving just £189.361 million (0.3%) of CCG spending, could not be linked to organisational websites or entries in the CC/CH registers.

Table : Count of suppliers by category and CC/CH Registration

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | *Found in:* | | | | *Total Suppliers* |
| *Category* | *CC & CH* | *CC not CH* | *CH not CC* | *Neither* |
| *NHS†* | 0 | 0 | 2 | 536 | 538 |
| *LA* | 0 | 0 | 0 | 212 | 212 |
| *GP Services* | 3 | 3 | 321 | 5,961 | 6,288 |
| *Care Home* | 67 | 7 | 547 | 154 | 775 |
| *Hospice* | 128 | 1 | 0 | 0 | 129 |
| *Categorised Other††* | 3 | 3 | 44 | 113 | 163 |
| *Other* | 535 | 67 | 1,667 | **188** | 2,457 |
|  | 736 | 81 | 2,581 | 7,164 | 10,562 |

† Two NHS organisations are listed as Private Limited Companies. NHS Property Services is wholly owned by the Department of Health, whilst NHS Shared Business Services is a joint venture between the DoH and French IT firm Sopra Steria.

†† “Categorised Other” comprises Government (incl. HMRC, Police & Fire Services, etc), Solicitors and Executors, Pharmacies and Opticians, Universities, Schools and Local Medical and Pharmaceutical Committees.

Table : Expenditure (£millions) on suppliers by category and CC/CH Registration

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | *Found in:* | | | | *Total Expenditure* |
| *Category* | *CC & CH* | *CC not CH* | *CH not CC* | *Neither* |
| *NHS†* | £0.000 | £0.000 | £113.805 | £54,148.588 | £54,262.880 |
| *LA* | £0.000 | £0.000 | £0.000 | £4,457.706 | £4,457.706 |
| *GP Services* | £5.078 | £3.444 | £721.666 | £5,541.260 | £6,271.449 |
| *Care Home* | £65.652 | £1.032 | £257.759 | £45.289 | £369.732 |
| *Hospice* | £201.115 | £0.639 | £0.000 | £0.000 | £201.754 |
| *Categorised Other††* | £0.453 | £1.833 | £13.509 | £252.879 | £268.674 |
| *Other* | £463.166 | £13.501 | £3,998.057 | **£189.361** | £4,664.086 |
|  | £735.463 | £20.450 | £5,104.796 | £64,635.572 | £70,496.281 |

Of course, some uncertainty also surrounds the status of the 6,416 non-NHS/LA organisations that cannot be found in the CC/CH registers (60.7% of all suppliers). However, these suppliers account for only 8.6% of CCG expenditure >£25k and, as registered companies (including Community Interest Companies) and charities with an annual income over £10,000 are legally required to publish their registration number and name on online publications, it seems reasonable to assume that the vast majority of ‘significant’ VCSEs would be identifiable as such.

# Evaluation of manual interrogation/extraction of expenditure data

The >£25 CCG accounts provide a reasonable basis for analysing expenditure patterns, though they do require significant Freedom of Information effort and an enormous amount of time to manually interrogate the data. The importance of this intensive approach is demonstrated by comparing the resulting dataset with expenditure data collected as part of the *NHS Spend* project[[14]](#footnote-14). This used fully automated data scraping methods to interrogate NHS trust and CCG accounts between 2010 and 2020. For 2018-19 spending data was obtained for only 129 CCGs, with 117,933 invoices over £25k (totalling £37.528 billion) referring to 13,090 named suppliers. As detailed in Table 5 below, this is substantially less than has been achieved in the current project – largely through persistent FoI requests. A detailed review of the collated accounts soon reveals, moreover, that the automated data scraping process resulted in a number of significant errors[[15]](#footnote-15).

Table : Comparison of data collected by the ‘NHS Spend’ and 3SC† projects

|  |  |  |  |
| --- | --- | --- | --- |
|  | Invoices >£25k | | |
|  | *NHS Spend Project* | *3SC Project* | % captured by *NHS Spend Projec*t |
| CCGs | 129 | 189 | 68.3% |
| Invoices | 117,933 | 225,889 | 52.2% |
| Expenditure | £37.528bn. | £70.496bn. | 53.2% |
| Named Suppliers | 7,651 | 10,929 | 70.0% |

† Our *Commissioning, Co-commissioning and Being Commissioned; the NHS and Third Sector Organisations* project is also known as the *3rd Sector Commissioning* project, or *3SC*.

As with the current project, the *NHS Spend* project sought to match suppliers with organisations listed in the CC and CH registers. Once again, being largely dependent on automated pattern matching techniques, even for those CCG accounts that were retrieved, a smaller number of suppliers could be matched with organisations in the CC and CH registers. Thus, with respect to CCGs covered by both datasets: the *NHS Spend* project identifies 504 charities rather than 623 in the present study (81%) and 1980 companies rather than 2550 (78%). With a rapid audit of putative links revealing a number of doubtful matches having been made in the *NHS Spend* project, there are strong reasons to argue that, at least at present, >25k expenditure data can only be used if subject to intensive manual scrutiny. Of particular concern is the extent to which the effectiveness of pattern matching varies between CCGs, with 17 and 19 CCGs returning less than 50% of known charities and companies respectively. A fully automated identification of suppliers clearly risks seriously biasing the analysis.

# Identifying Suppliers: Establishing VCSE Status

Returning to our *3SC Project*, any supplier found in the Charity Commission (CC) register (n=817) has been classified as VCSE (Voluntary, Community or Social Enterprise). Of these, as illustrated in Table 6 below, the vast majority (n=736) were also found in the Companies House (CH) Register; most (n=691) being listed as ‘Private Limited Companies by guarantee’. Relatively few registered charities were not also found in the CH register (n=81), possibly because of name variation.

Also categorised as VCSE is any company listed in the CH register as a Community Interest Company (n=127), Industrial and Provident Society (n=4), Registered Society (n=62) or a Social Enterprise Company (n=1). A less clear-cut category concerns suppliers registered as ‘Private Limited Companies by guarantee’ but which are not also found in the CC register. This legal form is commonly used by Not-for-Profit organisations and Social Enterprises, but is also used, for instance, by GP federations, Local Medical Committees, Academic Health Science Networks and other similar membership organisations. Our approach has been to search these organisations’ public-facing websites for ***explicit*** statements that they are Not-for-Profit, Social Enterprise or ‘volunteer-led’. If found, they are classed as VCSE (n=35). Otherwise, even though we may suspect them to be VCSE, they have been classified as ‘Not VCSE’.

Table : Supplier Types and VCSE Status

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***In CC Register and CH Register*** | | ***Suppliers*** | ***Spending (£m)*** | ***Status*** |
| Charitable Incorporated Organisation | | 36 | £6.557 | VCSE |
| Private Limited Companies by guarantee | | 691 | £724.221 | VCSE |
| Other Company Types † | | 9 | £4.685 | VCSE |
|  | |  |  |  |
| ***In CC Register but not CH Register*** | | ***Suppliers*** | ***Spending (£m)*** | ***Status*** |
| Named charities | | 81 | £20.450 | VCSE |
|  | |  |  |  |
| ***In CH Register but not CC*** | | ***Suppliers*** | ***Spending (£m)*** | ***Status*** |
| Community Interest Company | | 127 | £801.862 | VCSE |
| Industrial and Provident Society | | 4 | £9.944 | VCSE |
| Registered Society | | 62 | £177.226 | VCSE |
| Social Enterprise company | | 1 | £0.048 | VCSE |
| Private Limited Companies by guarantee | | 35 | £161.333 | VCSE |
| Private Limited Company | | 1 | £2.965 | VCSE |
| Private Limited Companies by guarantee | | 68 | £26.149 | Not VCSE |
| Other CH Company Types † | | 113 | £146.280 | Not VCSE |
| Private Limited Company | | 2,168 | £3,665.184 | Not VCSE |
|  | |  |  |  |
| ***Identified as NHS, LA or GOV Organisations*** | | ***Suppliers*** | ***Spending (£m)*** | ***Status*** |
| NHS Organisation | | 538 | £54,262.880 | Not VCSE |
| Local Authorities | | 212 | £4,457.706 | Not VCSE |
| Government Bodies | | 8 | £220.807 | Not VCSE |
|  | |  |  |  |
| ***Other suppliers not in CC or CH Registers*** | | ***Suppliers*** | ***Spending (£m)*** | ***Status*** |
| Other Suppliers | | 4 | £3.118 | VCSE |
| Other Suppliers | | 6,404 | £5,804.865 | Not VCSE |
|  |  |  |  |  |
|  | ***VCSE Suppliers*** | 1,051 | £1,912.409 |  |
|  | ***Not VCSE Suppliers*** | 9,511 | £68,583.872 |  |
|  |  |  |  |  |
|  | ***Total all suppliers*** | 10,562 | £70,496.281 |  |

† ‘Other CH Company Types’ include Investment Companies, Limited Liability Partnerships & Limited Partnerships, Overseas Entities, Private Unlimited Companies & Public Limited Companies, and Royal Charter Companies.

Much less commonly, Private Limited Companies (i.e. limited liability by shares rather than by guarantee) can be set up as VCSE. Once again, if a supplier’s website explicitly claims it is, for instance, a Social Enterprise, then it has been classed here as a VCSE. Only 1 such instance has been found, although we did not systematically search all 2,160 Private Limited Company websites.

The 6,341 ‘Other Suppliers’ that were not found in either the CC or CH registers were also left as ‘Not VCSE’ unless their websites were found and contained explicit claims that they were VCSE. Only 4 such suppliers were identified, though there is little doubt that a significant proportion will, in fact, be VCSE. The *2013 Greater Manchester State of the Voluntary Sector* report[[16]](#footnote-16) estimated, for instance, that there were 9,624 voluntary organisations in Greater Manchester, of which only 4,968 had been registered. ***It is highly likely that many small ‘below-the-radar’ VCSE organisations lie hidden within the ‘Other Suppliers’ category.***

The overall national picture, therefore, is that 1,051 (10.0%) of the 10,562 unique suppliers receiving >£25k in the CCG accounts have been identified as VCSE. They received just £1,912.409 million (2.7%) of the total £70,496.281 million spent by CCGs.

# National Overview of CCG Spending on VCSE Suppliers

CCG spending on VCSEs is highly skewed, with relatively few receiving substantial funding and a very long tail of more minor suppliers (Figure 4). This tail would have been far more pronounced had been possible to include invoices of less than £25k.

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Figure : National (189 CCGs) expenditure on individual VCSEs; 2018/19

In 2018/19 just six VCSEs (named above) received more than £50m. from across all 189 CCGs for which there are reliable data, and together they received 23.5% of the total national CCG spend on VCSEs. Some 34 suppliers received more than £10m (totalling 60.6% of total VCSE spend), and 242 suppliers more than £1m (91.1% of total VCSE spend). Figure 5 below highlights the major VCSEs in terms of either total income from CCGs or the number of CCGs in which they have at least some presence. These organisations contrast markedly with the vast bulk of VCSEs which receive relatively little from only a small number of CCGs.

A picture containing chart

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Figure : Total CCG spending on VCSEs against number of CCGs served

The dependency of VCSEs, however large, on just a few CCGs (e.g. The Livewell Foundation, City Health Care Partnership and Sirona Care & Health) is likely to affect how they engage in the commissioning process and will likely contrast with VCSEs with multiple commissioning relationships (such as Marie Curie, Marie Stopes International, Integrated Care 24, the BPAS and Nuffield Health). Commissioning relationships will, of course, also reflect the extent to which individual VCSEs are dependent on CCG income within their overall portfolio of activity – but this cannot be captured through an analysis of CCG accounts alone.

The City Health Care Partnership[[17]](#footnote-17), for instance, had annual revenue of £122.810m in 2018/19, meaning that just two CCGs (Hull and the East Riding of Yorkshire) constituted over 67% of its total income. In contrast, Marie Stopes International received over £296m from across multiple countries[[18]](#footnote-18), meaning that even the largest of its CCG funders (Greenwich) only contributed 0.25% towards its overall income.

The CCG accounts can provide a valuable starting point for understanding the context within which individual VCSEs operate. An analysis of overall patterns of VCSE dependency lay well beyond the scope of the *3SC Project*, although such information has informed our investigation of commissioning relationships within the six case study sites selected for detailed investigation.

# CCG Variation in Spending on VCSE Suppliers

The selection of the study sites aimed to capture a ‘maximum-variety’ of CCGs in terms of their engagement with VCSEs, although secondary criteria included capturing, as far as possible, a range of CCG budget sizes, urban/rural contrasts, diversity in terms of ethnic composition and deprivation, as well as commissioning arrangements (i.e. the different ways in which CCGs coordinated with other NHS bodies and local authorities).

Understanding how expenditure on VCSEs varies between CCGs is thus crucial, and this reflects what may constitute two quite separate processes: first, the extent to which different CCGs were willing to commission non-NHS/LA organisations (whether corporate or VCSE), and second, having ‘contracted-out’ certain health and care activities, the extent to which CCG then chose to commission VCSEs.

With regard to the former there is, as illustrated by Figure 6, huge variation in the proportion of CCG spending on non-NHS/LA suppliers; from 47.3% (East Staffordshire) to just 1.4% (Crawley). There may, as illustrated by Figure 7, be some geographical concentration in the use of non-NHS/LA suppliers in Eastern England north and south of The Wash as well as in the North West Midlands. The regional tendency is not, however, pronounced and, with CCGs exhibiting high and low contracting-out rates often being coterminous, the use of non-NHS/LA suppliers does appear to be a local CCG decision.

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Figure : Relative Split of CCG spending on NHS/LA and other suppliers

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Figure : Map of relative split of CCG spending on NHS/LA and other suppliers

The extent to which CCGs then direct any non-NHS/LA expenditure towards VCSEs also varies hugely, as illustrated by Figure 8 (which shows VCSE spend relative to both (a) NHS/LA and (b) non-NHS/LA non-VCSE spend) and Figure 9 (which focuses on the split of non-NHS/LA spend between VCSE and non-VCSE suppliers).

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Figure : Relative split between NHS/LA, VCSE and other suppliers

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Figure : Relative split of non-NHS/LA spend between VCSE and non-VCSE suppliers

The proportion of non-NHS/LA CCG expenditure directed to VCSEs thus varies from 69.2% and 68.3% in Greater Huddersfield and North East Lincolnshire respectively, to less than 1% in Portsmouth, Wyre Forest, and Fareham & Gosport CCGs. Full details are available on the project *github* site (see *CCGSpendingSplit.csv*).

As illustrated by Figure 10, there is some suggestion of a regional pattern in VCSE commissioning although, as CCGs exhibiting high- and low-VCSE engagement are often coterminous, the use of VCSEs by different CCGs most likely reflects predominately local rather than regional factors.

Map

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Figure : Map of relative split of non-NHS/LA spend between VCSE & non-VCSE suppliers

This split between VCSE and non-VCSE suppliers could have been used as the basis for identifying a ‘maximum-diversity’ selection of case studies, but the *relative* split doesn’t say anything about the absolute level of VCSE engagement in different CCGs. For this the two obvious criteria are (a) the percent of overall CCG spending on VCSE suppliers (Figure 11) or (b) per capita CCG spending on VCSE suppliers (Figure 12). The two are highly correlated but, as per capita spend provides the more explicit measure of the importance of VCSE suppliers to local health economies and the populations they serve, this was used to identify suitable case study sites for the *3SC Project*.

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Figure : Percent Overall CCG Spending of VCSE Suppliers

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Figure : Per capita CCG Spending on VCSE suppliers

# Shortlisting Potential Study Sites for the 3SC Project

Study site selection was thus based on ranking 2018/19 CCGs in terms of per capita VCSE spend and then, using data on the secondary selection criteria (budget size, urban/rural, ethnic composition, deprivation and broad commissioning arrangements), aiming for a short list of two preferred and one reserve CCG from each quartile. The *3SC Project* team then sought to recruit up to eight CCGs as case study sites.

The overall distribution of short-listed CCGs is indicated in Figure 13 (where, to maintain study site anonymity, rank order position has been randomly ‘jittered’ by between +3 & -3).

Chart

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Figure : Short-list of potential case-study CCGs (points jittered to preserve anonymity)

The final distribution of case study sites depended partly on which CCGs were willing to collaborate, but also on the ongoing reorganisation of CCGs. An important practical difficulty was that by the time CCGs were approached (in 2020) the number of CCGs had fallen from the 195 extant in 2018/19 to just 135 – and many of those on the shortlist had amalgamated with neighbouring CCGs. As a result the final selection of CCGs is somewhat less evenly distributed than intended, as illustrated in Figure 14. The final selection nevertheless includes a wide variety of CCGs, from those likely to have complex, extensive and diverse commissioning relationships between healthcare commissioners and VCSEs through to those which make relatively scant use of VCSE suppliers.

Chart

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Figure : Final distribution of case-study CCGs (points jittered to preserve anonymity)

Bespoke reports detailing what could be extracted from the 2018/19 CCG accounts were provided to, and discussed with, panels from each of the study sites. Although these provided a useful point around which to discuss the volume and nature of VCSE commissioning in each CCG, they cannot be shared here as they would compromise the anonymity of the CCGs.

**For the team: remove before making publicly available on github**

In terms of the 2020 geography, our study sites are located as follows:

Chart

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# Improving the “Over-Threshold” expenditure accounts for Health Service Research

As noted in the introduction, despite its obvious potential relatively little health service research has sought to utilise the “over-threshold” expenditure data collected by CCGs and NHS Trusts since 2013. The *NHS Spend Project* discussed in Section 4 stands as a notable exception but, depending as it did almost entirely on automated data-scraping and name-matching algorithms, it arguably serves to demonstrate that the expenditure data, at present, cannot adequately support such methods. This represents a missed opportunity, not least because the problems largely lie with the implementation, rather than the ambition, of HM Treasury’s guidelines[[19]](#footnote-19). We draw particular attention to the need to rigorously enforce the following:

* The “over-threshold” accounts must be published in csv format. The common practice of making files available in pdf format makes the accounts extremely difficult to use.
* The accounts must be made available using permanent *url* addresses to support the use of Reproducible Analytical Pipelines and ensure future availability. With the reorganisation of commissioners and ongoing churn of health providers – and resulting loss of both institutional memory and data – this requires that all accounts are submitted to [www.data.gov.uk](http://www.data.gov.uk) or similar permanent central depository.
* Greater attention needs to be paid to data entry and quality control. Organisations should not use generic terms (e.g. ‘GP’, ‘Primary Care’ or ‘Prescribing Support Services’) rather than actual supplier names, and our experience points towards an unacceptable number of non-standard, misnamed and mis-dated accounts; indicative, we suspect, of organisations seeking to meet their quasi-legal responsibilities rather than aiming to provide useful data.
* All organisations are required to make the monthly “over-threshold” accounts available in .csv format and, where there are problems, their response to requests for accounts should be quick and effective. This was not always the case and, even after formal Freedom of Information (FoI) requests, we were unable to obtain 2018/19 data for four CCGs.

HM Treasury’s guidance is now somewhat dated, and certainly pre-dates the widespread adoption of data-scraping and other automated techniques used to process large and complex datasets. The following would greatly enhance the value of the “over-threshold” accounts to health services research:

* Local variation in how suppliers are named poses significant problems. Where organisations are registered companies or charities the inclusion of Company House and/or Charity Commission registration numbers would be invaluable.
* With the huge reduction in the number of commissioners (down to the current 42 Integrated Care Systems (ICS)) there has been a concomitant loss of information on how spending varies geographically. The use of supplier postcode, which is currently rare even though HM Treasury’s guidance states that this should be published if available, would help. It would also greatly help developing an understanding of spending patterns if ICS “over-threshold” accounts state whether particular invoices referred to pan-ICS activity, or were focussed on one or more of the ‘places’ or ‘neighbourhoods’ into which ICS are now divided.

1. HM Treasury (2013) *Guidance for publishing spend over £25,000* (<https://tinyurl.com/4m9p23hp)>. [↑](#footnote-ref-1)
2. Rahal, C. (2018) The Keys to Unlocking Public Payments Data. *Kyklos*, 71: 310– 337. doi: [10.1111/kykl.12171](https://doi.org/10.1111/kykl.12171); Rahal, C., & Mohan, J. (2022). The Role of the Third Sector in Public Health Service Provision: Evidence from 25,338 heterogeneous procurement datasets. *SocArXiv*, (https://doi.org/10.31235/osf.io/t4x52); Goodair, B. & Reeves, A. (2022) Outsourcing health-care services to the private sector and treatable mortality rates in England, 2013-20: an observational study of NHS privatisation, *The Lancet Public Health*, 7(7) E638-E646, July 01, 2022 (DOI: <https://doi.org/10.1016/S2468-2667(22)00133-5>). [↑](#footnote-ref-2)
3. NIHR (2020) *Commissioning, Co-commissioning and Being Commissioned; the NHS and Third Sector Organisations. Multi-method realist study. Protocol*. HSDR 18/92 Evaluating approaches to health and care services commissioning and provision with the third sector in the UK (<https://tinyurl.com/fuxbj76x>). [↑](#footnote-ref-3)
4. Reproducible Analytical Pipelines (RAP) are automated statistical and analytical processes which aim to ensure that research is reproducible, auditable, efficient, and high quality. Considered best practice, they depend on the availability of permanent open-source data. (<https://tinyurl.com/ycy5b7d4>) [↑](#footnote-ref-4)
5. *CCG Spend on VCSEs, 2018/19: Data & Analysis* (2023) <https://github.com/AlexGibsonPlymouth/3SC.git> [↑](#footnote-ref-5)
6. When well formatted the Tabula conversion program could be used (<https://tabula.technology/>) to convert to CSV. This wasn’t possible for the City & Hackney, Newham, and Horsham & Mid Sussex accounts. [↑](#footnote-ref-6)
7. NHS England (2018) *Clinical Commissioning Groups’ accounts (2016-17)* (<https://tinyurl.com/333fyndk>). [↑](#footnote-ref-7)
8. Virgin (2021) *Introducing HCRG Care Group*. 1 Dec 2021. (<https://tinyurl.com/cyyxee2k>) [↑](#footnote-ref-8)
9. Twenty20Capital (2021) *How we work*. (<https://twenty20capital.com/how-we-work/>) [↑](#footnote-ref-9)
10. NHS Digital (2019) *NHS Payments to General Practice - England, 2018/19* (https://tinyurl.com/hkkxcmeu) [↑](#footnote-ref-10)
11. David Robinson (2020). *fuzzyjoin: Join Tables Together on Inexact Matching*. R package version 0.1.6. https://CRAN.R-project.org/package=fuzzyjoin. [↑](#footnote-ref-11)
12. Care Quality Commission (2022) *Using CQC data* (with links to the CQC active and deactivated locations directories). (https://www.cqc.org.uk/about-us/transparency/using-cqc-data). [↑](#footnote-ref-12)
13. Rahal, *The Keys to Unlocking Public Payments Data* (p316). [↑](#footnote-ref-13)
14. C Rahal (2021) *NHSSpend: Tools and data for NHS procurement* (<https://github.com/crahal/NHSSpend>) [↑](#footnote-ref-14)
15. An initial review shows that the data for South West Lincolnshire has been duplicated and entered under “NHS\_SWOR\_CCG“ (an acronym which does not appear to match any CCG); data for Crawley CCG appears to include invoices from Horsham & Mid Sussex CCG, and the Surrey Downs data has been corrupted, seemingly by the inclusion of subtotals. Other problems may exist. [↑](#footnote-ref-15)
16. Dayson, C. et al. (2013) *Greater Manchester State of the Voluntary Sector 2013*. Centre for Regional Economic and Social Research. Sheffield Hallam University. (<https://tinyurl.com/y53jbu8u>) [↑](#footnote-ref-16)
17. *Accounts for City Health Care Partnership, year ending 31 March 2019* (<https://tinyurl.com/5afkr99z>). [↑](#footnote-ref-17)
18. *Accounts for Marie Stopes International, year ending 31 December 2018* (<https://tinyurl.com/4rknhzbx>). [↑](#footnote-ref-18)
19. HM Treasury (2013) *Guidance for publishing spend over £25,000* (<https://tinyurl.com/4m9p23hp>). [↑](#footnote-ref-19)